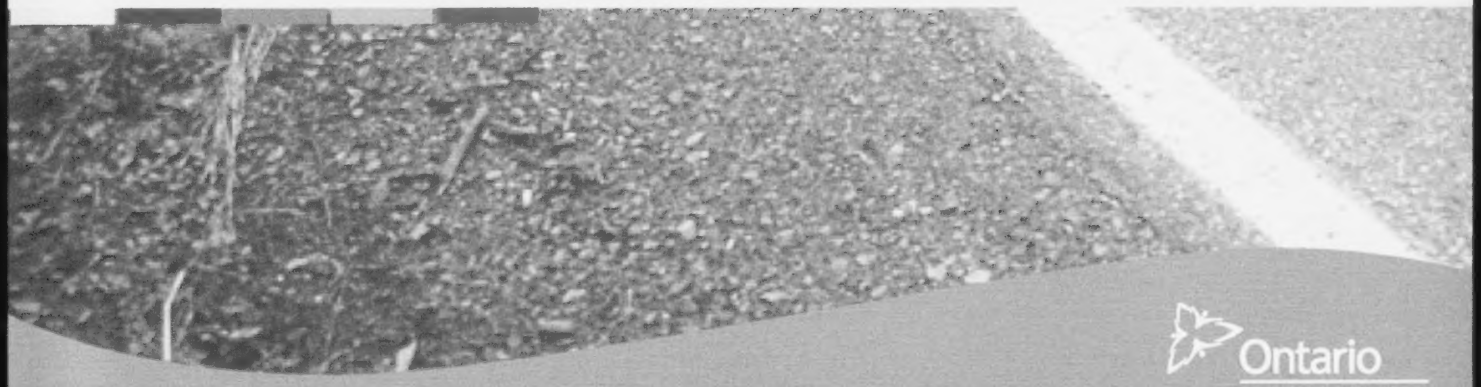
Erie St. Clair **LHIN**
RLISS d'Érié St. Clair
www.eriestclairlhin.on.ca

Navigating Change in the Right Lane

Integrated Health Service Plan
IHSP 2010 – 2013 | December 2009



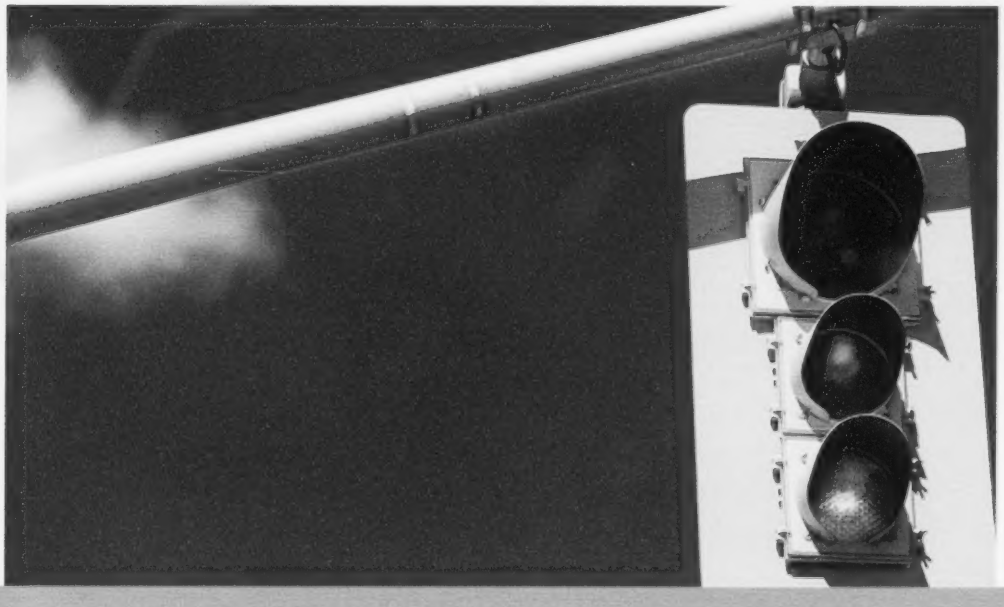
Ontario
Erie St. Clair Local Health Integration Network

Table of Contents

Section 1: Introduction and Context 3
Section 2: Summary of Provincial Strategy / Alignment of IHSP to Strategy 16
Section 3: ESC LHIN's Vision for the Local Health Care System 19
Section 4: Overview of the Erie St. Clair Local Health Care System 22
Section 5: Framework for Planning 30
Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System 34
Section 7: Rationale for Strategic Directions/Goals 43
Section 8: How Success will be Demonstrated – Actions and Measures 47

List of Tables

Table: Ongoing ESC LHIN Planning Themes and ESC LHIN Lead Areas 13
Table: ESC LHIN Three-Year Strategic Targets to Achieve Vision, Mission and MLAA Targets 14
Table: Erie St. Clair Population Demographics based on 2006 Canadian Census 24
Table: Life Expectancy in Erie St. Clair 26
Table: Prevalence Rates for Selected Chronic Conditions, Erie St. Clair and Ontario, 2007 27
Table: Erie St. Clair LHIN 2009/10 Funding by Major Program Area 28



Section 1: Introduction and Context

LHIN Background:

The Erie St. Clair Local Health Integration Network (ESC LHIN) is one of 14 Local Health Integration Networks (LHINs) in Ontario.

Local Health Integration Networks were established across the province in 2006 to plan, fund and co-ordinate health care services delivered by:

- Hospitals
- Long-Term Care (LTC) Homes
- Community Care Access Centres (CCACs)
- Community Support Service (CSS) Agencies
- Mental Health and Addictions Agencies
- Community Health Centres (CHCs)

Local accountability gives communities the opportunity to get involved in health care planning.

The Erie St. Clair LHIN serves the regions of Chatham-Kent, Sarnia/Lambton and Windsor/Essex, which includes over 649,000 people. The ESC LHIN oversees an annual budget of more than $900 million for local health care services.

Sector	Budget 2008/09 (Million)
Hospitals	$586.4
Long-Term Care	153.6
Community Care Access Centre	99.8
Mental Health Agencies	26.9
Community Health Centres	16.1
Community Support Services	15.0
Addictions Agencies	7.6
Assisted Living Services	5.1
Subtotal	$914.8
Initiatives	2.4*
LHIN Operations	4.2**
Grand Total	$921.4

* Reflects funding not yet allocated for Aging at Home, Urgent Priorities Funding, FLO Collaborative (quality improvement project) and Emergency Department Action Plan (EDAP)

** Reflects December 31, 2008 Financials

Section 1: Introduction and Context

The Erie St. Clair LHIN's Health Care Vision:

A health care system that helps people stay healthy, delivers good care to them when they are sick and will be there for their children and grandchildren.

The Erie St. Clair LHIN's mandate is to create a local health care system that:

- Provides a seamless experience for the patient
- Provides services to meet the multiple needs of patients and families
- Makes effective and efficient use of the resources and capacity within the system

The Erie St. Clair LHIN believes the health care system needs to be:

- Focused on the patient, high quality, publicly-funded, sustainable, universally accessible and results-based
- Operated in a transparent manner with honesty and integrity by being accountable to our community
- Co-ordinated, with health care providers working co-operatively with each other, using best practices and striving for excellence

The Erie St. Clair LHIN's Integrated Health Service Plan 2010-2013 is our strategic plan for integrating and improving health services in our region. It is consistent with the above vision and the strategic directions of the Ministry of Health and Long-Term Care (MOHLTC). It sets out the priority areas that will guide our LHIN activities over the next three years.

Section 1: Introduction and Context

Previous Integrated Health Service Plan - IHSP 2006-2009:

It has been three years since the ESC LHIN completed its initial IHSP: Our People, Our Health, 2006-2009. The 2006 plan considered three major elements to determine the ESC LHIN's focus: Ministry-LHIN Accountability Agreement (MLAA) Targets, Ministry of Health and Long-Term Care Priorities, and LHIN IHSP Strategic Directions.

MLAA Targets (2006)	Ministry of Health and Long-Term Care Priorities (2006)	LHIN IHSP Strategic Directions (2006 to 2009)
• Access indicators - wait times • Quality indicator - acute myocardial infarction (AMI) readmit • Integration indicators - alternate level of care (ALC), targeted reasons for emergency department visits, inpatient admissions • e-Health development • Surgical wait times • Pediatric surgery wait times • Emergency department wait times	• Reducing emergency department wait times • Family health care • Sustainability • Chronic disease • Mental health and addictions	• Chronic disease management • Reduce dependence on hospital services • Supporting people at home • Back office / administration integration • System navigation • Health human resources • Health promotion/illness prevention • Timely access to care

Since many aspects of the above elements complemented each other, the ESC LHIN established a structure to effectively and efficiently address the eight strategic directions. The ESC LHIN used community, stakeholder, and ESC LHIN resources to develop an activity framework and to implement it. The ESC LHIN established several Clinical Advisory Networks to:

1) serve as experts in advancing clinically-oriented integration opportunities;
2) provide advice for a better understanding of our local health care system; and
3) advance planning recommendations.

Section 1: Introduction and Context

The following advisory networks were developed and/or supported by the ESC LHIN:

- Emergency / Medical Department Advisory Network
- Alternative Level of Care Advisory Network
- Surgical Advisory Network
- Mental Health and Addictions Advisory Network
- Rehabilitation Advisory Network
- Regional Diabetes Network

Legislative and specialty-focused committees were also established to meet specific legislative priorities and objectives. These included the following:

- Health Professionals Advisory Committee (HPAC)
- Comité d'action santé d'Érié St-Clair
- Local Aboriginal Health Planning Entity (LAHPE)
- Governance Advisory Committees (one per county)

Task-oriented committees were struck in order to achieve time-limited tasks or priority-based objectives. Below are the task committees the ESC LHIN established in order to further its strategic directions:

- Aging at Home Advisory Network and subcommittees
- Wait Times committees
- CEO Leadership committees
- End of Life committee

The eight strategic directions outlined in the initial IHSP shaped the activities of the ESC LHIN in its first three years. These directions became the foundation for our examination of funding initiatives, enhancements, fiscal recoveries and service co-ordination. The ESC LHIN strived to remain strategic in its activities through the development of the above networks, task-oriented committees and governance advisory bodies that guided the receipt of focused feedback and advanced action-oriented initiatives.

As part of the activity framework used for the first three years, the ESC LHIN examined service delivery on a county-by-county basis in order to:

- Understand the nature of the demand, supply and distribution of services
- Focus on areas of greatest need and other regional disparities
- Understand the nature of high risk populations
- Understand unique geographic characteristics and the impact of geography on core service delivery and outcomes
- Consider known barriers and challenges
- Consider the availability of resources
- Partner with other interested organizations
- Understand primary care weaknesses and opportunities

Using the above context and experience as a baseline, the ESC LHIN guided Aging at Home Strategy resources and Urgent Priority Funding resources to address the identified local needs and opportunities. The Table below provides information on specific projects/priorities supported through these initiatives over the past year. (See Appendix D for more detail on these areas).

Aging at Home 2009-2010	
Direct Interventions:	**Investments:**
Specialized Geriatric Services for ED Resources	$760,000
Geriatric Emergency Medicine Nurses (10)	$1,000,000
Supportive Housing (30 units)	$750,000
Leamington Mennonite Home Emergency Response	$45,000
Long-Term Care Beds (20)	$1,600,000
Kettle and Stony Point Assisted Living Funding	$291,000
Total	$4,446,000
Diversion Interventions:	**Investments:**
Restorative Ambulation Team	$500,000
End of Life Team for Chatham-Kent	$500,000
Rapid Response Team	$500,000
Total	$1,500,000
Preventative Interventions:	**Investments:**
Day Program	$40,000
Friendly Visiting	$300,000
Home Maintenance and Repair	$500,000
Total	$840,000

Section 1: Introduction and Context

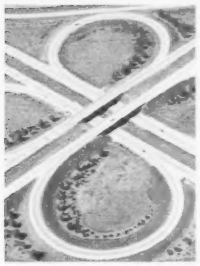
Urgent Priorities Fund Summary 2009-2010	
Approved for 2009-2010:	**Total:**
Watford CHC	$191,000
CHC Integration	$30,000
Utilization Management Improvements	$200,000
HDGH Psychiatric Team	$450,000
CCAC Operational Review	$250,000
Diagnostic Imaging Improvements WE	$20,000
CHIS enhancements	$50,000
CEE Complex Continuing Care Beds	$200,000
Malden Park interim Beds	$170,000
Lambton Transitional Beds	$100,000
Chatham-Kent Transitional Beds	$100,000
Essex Transitional Beds	$340,000
Aboriginal Consultant	$55,000
CEE Complex Continuing Care Beds (II)	$200,000
SL Transportation Providers Brochure	$7,000
Total	$2,363,000

During its first three years of operational responsibility, the ESC LHIN directed its energy and actions toward the following initiatives:

- Alternate level of care (ALC) improvements in Windsor/Essex and Sarnia/Lambton
- Examining the potentially vulnerable and potentially unsustainable small community emergency departments
- Establishing a planning exercise, StrategiCare, to examine the potential for enhanced regional integration of programs in Windsor/Essex
- Promoting the integration of the local Essex CHCs for a more sustainable organization and to provide a platform for future enhancements
- Integrating local Canadian Mental Health Association (CMHA) services to develop a standardized, efficient, and increasingly effective organization LHIN-wide

In summary, ESC LHIN activities to improve the local health system focused on four main outcomes:

Improved Access



- The ESC LHIN created long-term care, Complex Continuing Care (CCC) and alternate level of care deferral beds to help sustain acute care services
- The ESC LHIN invested in meal enhancements to enable seniors to stay at home
- The ESC LHIN invested in transportation to decrease the incidence of social isolation for seniors and to help them connect to health care services

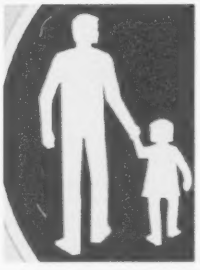
Improved Quality

- The ESC LHIN helped implement best practices through investment in an Emergency Department (ED) and Critical Care Lead
- The ESC LHIN examined diagnostic and pharmacy services
- The ESC LHIN invested in programming for visually impaired residents through agencies such as Canadian National Institute for the Blind (CNIB)
- The ESC LHIN invested in home palliative care services
- The ESC LHIN invested in standardized utilization tools

Cost Effectiveness

- The ESC LHIN supported and invested in Lean/Six Sigma (business improvement methodology) initiatives
- The ESC LHIN participated in the FLO Collaborative (quality improvement project)
- The ESC LHIN sponsored the CCAC Operational Review
- The ESC LHIN made timely funding recoveries and subsequently transferred funds to organizations with strategic needs and pressures

Co-ordination



- The ESC LHIN enhanced integration initiatives in Windsor/Essex Hospitals
- The ESC LHIN integrated Windsor/Essex CHC services
- The ESC LHIN integrated CMHA services

Section 1: Introduction and Context

Navigating Change in the Right Lane, IHSP 2010-2013:

For the 2010-2013 timeframe, the overall direction of the ESC LHIN Integrated Health Service Plan has moved from being primarily a strategic, conceptually-based plan to an action-focused and results-based plan.

The priorities are derived from seven Strategic Aims that will help the ESC LHIN achieve its mission. These are:

- Developing alternatives to emergency department care
- Ensuring appropriate access to surgical, Intensive Care Unit (ICU) and medicine beds
- Ensuring appropriate access to long-term care supports closer to home
- Reducing the impact of diabetes
- Reducing the impact of mental health and addictions
- Addressing the impact of chronic disease
- Improving system performance by building on the current strengths of the local health care system

The five confirmed IHSP Strategic Directions for 2010 – 2013 are:

- Improved outcomes in alternate level of care
- Improved outcomes in emergency department care
- Improved outcomes in diabetes management (chronic disease management)
- Improved outcomes in mental health and addictions
- Improved outcomes in rehabilitation care and interventions

Four strategic projects are also planned for this three-year period:

- The examination of diagnostic imaging, laboratory and pharmacy services
- Complex Continuing Care program standardization
- Development of a system-wide clinical services plan
- Attention to health human resources

The concluding sections of the our IHSP 2010-2013 address the priority populations to be served, system improvement goals, actions required to address these goals, and performance objectives and targets. These elements are covered in detailed Annual and 90 day Action Plans (See Appendix E for detailed Annual and 90-day Action Plans) which identify the specific actions that are needed to achieve the goals and the lead accountabilities. The ESC LHIN will use these 90-day review cycles to monitor progress and ensure that established targets are met and adjustments made as required.

In establishing the above priorities, the ESC LHIN began a detailed process that included consideration of the new Ministry-LHIN Accountability Agreement performance indicators, Ministry of Health and Long-Term Care priorities, community engagement findings, ESC LHIN Board input, and a comprehensive review of the data including population characteristics, population health, and an assessment of service resources and programs.

A brief overview of key process elements follows to provide further context for our strategic aims and priorities for the next three years.

The ESC LHIN considered the elements in the table below to establish our IHSP Strategic Directions for 2010-2013.

MLAA Indicator	MLAA 09-10 Target	MINISTRY OF HEALTH AND LONG-TERM CARE 2010 Priorities
90th percentile wait times for Cancer Surgery	45	Improve access to emergency department care by reducing the amount of time that patients spend in the emergency department waiting Improve access to hospital care by reducing the amount of time that patients spend in alternate level of care beds Improve access to integrated diabetes care by supporting the roll-out of the current diabetes strategy Mental Health and Addictions (LHINs to roll out Ministry of Health and Long-Term Care 10-year strategic plan) Building on an e-Health framework
90th percentile wait times for Cardiac By-Pass Procedures	n/a	
90th percentile wait times for Cataract Surgery	78	
90th percentile wait time for Hip Replacement Surgery	162	
90th percentile wait time for Knee Replacement Surgery	182	
90th percentile wait times for MRI Scan	36	
90th percentile wait times for CT Scan	44	
Percentage of Alternate Level of Care Days	9	
Median Wait Time to Long-Term Care Home Placement	75	
ED Length-of-Stay (ED LOS) indicators: • Proportion of admitted patients admitted within LOS target of < 8hrs; • Proportion of non-admitted high acuity patients treated within respective LOS targets of: < 8hrs for Canadian Triage and Acuity Scale (CTAS) 1-2; < 6hrs for CTAS 3; • Proportion of non-admitted low acuity patients treated within LOS target of < 4hrs.		

The ESC LHIN also launched an inclusive community engagement strategy to inform, educate, consult, involve and collaborate with our stakeholders. (See Appendix C for detailed community engagement findings.) The table below lists the activities undertaken to establish IHSP priorities and develop the proposed action plan, and the participants who were involved. (For more detail on the community engagement strategy see Appendix A.)

Section 1: Introduction and Context

Method	Description	Number of Engagements	Total Participants
Key Informant Interviews	Interviews conducted by a third-party consultant with a targeted participant group representative of various health care sectors and stakeholders.	13	18
Consumer Focus Groups	Focus groups with diabetes and mental health and addictions consumers.	11	219
Stakeholder Consultations	Dialogue with committees representing system partners and/or priority populations.	7	77
Network Action Planning	Collaborative planning exercise with LHIN Advisory Networks involving the development of regional and geographically specific Action Plans for the IHSP 2010-2013 Planning Priorities.	35	90
Annual Conference Action Plan Workshops	Workshops held as part of the ESC LHIN Annual Conference focused on the review and collection of feedback for the Action Plans developed to support the Planning Priorities.	3	200
Social Media Engagement (Facebook)	Engagement of general public and stakeholders with the sharing of information and posting of questions on the social networking site, Facebook.	n/a	73
Total		69	677

The ESC LHIN carried out a comprehensive review of all available data including population characteristics, population health, and assessment of service resources and programs (see Appendix B) to develop hypotheses aimed at establishing strategic directions. The ESC LHIN staff and consultants then considered the Decision-Making Framework (refer to Section 5 of this report for details) to further assist in determining priorities. From this, hypotheses were finalized and presented to the ESC LHIN Board for consideration and support.

The ESC LHIN is now involved in a number of planning exercises with designated ESC LHIN

Leads and will continue to work toward significant short-term and strategic improvements over the next three years. Two key areas that the LHIN is focused on is improving Aboriginal Health and addressing the needs of the Francophone Communities.

With regard to Aboriginal Health Planning and Support, the LHIN provides financial resources to Kettle and Stony Point for an Assisted Living Centre. A new agreement with Aamjiwnaang First Nation for congregate dining for Seniors in their community commenced in 2009. The LHIN also provided two vans for client transportation to Walpole Island in previous years through Aging at Home and is currently in discussion with Walpole Island regarding the Community Health Centre deployment. In March 2009, the LHIN sponsored a Conference with its Aboriginal communities in order to obtain feedback on current issues, needs and risks Common issues reported by all communities were those of Mental Health and Addictions and Diabetes services. The LHIN, with the assistance of a Local Health Aboriginal Planning Entity, will develop actions to take advantage of new diabetes and mental health service opportunities.

In Erie St Clair, the Francophone population accounted for approximately 21,000 residents representing 3.4% of the total population (2006 Census data). Recent work of the LHIN has confirmed that the Francophone population faces significant issues related to health care accessibility and quality in the region (e.g. a general lack of health services in French). Even with the identification of a number of health service providers, the delivery of health services in French remains fragmented and there is a general lack of awareness and/or sensitivity to the needs of this community. Finally, a continuing lack of French-speaking health human resources is frustrating efforts to improve access to services in the preferred language of consumers. The LHIN will continue to engage its Francophone communities and seek solutions that considers current programs and services, future needs and issue resolution with the goal of improved access, quality and sustainability for this group. (See Appendix F for ESC LHIN Lead Detailed Reports (both for Aboriginal Health and French Language and other key areas and Key Theme Reports.) The themes and ESC LHIN Leads are listed in the table below:

Table: Ongoing ESC LHIN Planning Themes and ESC LHIN Lead Areas

Themes	LHIN Lead Areas
System Navigation	French Language
Primary Care (access and capacity)	Aboriginal Health Care
Health Promotion and Illness Prevention	Infection Control
Consumer Health Care Self-Management	Pharmacy
Integration (e.g., CHC, CMHA)	Critical Care
Planning and Performance	e-Health
Health Human Resources	Diagnostic Imaging

Section 1: Introduction and Context

The ESC LHIN also felt it was important to introduce a set of high-level health care system targets that link directly to the ESC LHIN vision, mission and MLAA in a more applied sense and provide guidance to annual service planning. (See Appendix G – Health System Targets.) Therefore, the ESC LHIN will establish a performance system monitoring process that aligns with the 90-day Action Plans and considers the direct relationship between benefits to the patient population served, the quality of the consumers' experience and the cost to the system (Triple Aim Approach – see appendix H).

Further, as shown in the table below, the LHIN will examine the current configuration of existing hospital beds and try to realign the bed designations to achieve greater long term efficiency and effectiveness of care. The table identifies preliminary targets for acute, rehabilitation, Complex Continuing Care, and mental health beds. The ESC LHIN's objective is to maintain the present number of beds, but redefine them to increase their effectiveness. The model of care for the identified beds will be adjusted to improve service delivery function and outcomes.

Table: Ongoing ESC LHIN Planning Themes and ESC LHIN Lead Areas

Measure	Baseline (2010)	2013 Target % Change
Helping us achieve Provincial Priorities of Emergency wait times and ALC reduction		
All ALC Days	31,169	-20%
Conservable Days/1000	131	-10%
ED Admissions %	10%	-10%
ED Visits by CTAS/1000:	476	-12%
ED Total Hrs. over target	221,027	-15%
% Discharge Home with or without services	67%	5%
% Transferred to a continuing care facility – LTC or Retirement Residence (RR)	21%	-52%
Hospital Discharges Safely Deferred from LTC to Home	151	-50%
Rebalancing Beds		
Acute Beds	907	-11%
Complex Continuing Care Beds	313	15%
Rehab Beds	124	30%
Psych Beds (excludes tier divestment of tertiary)	122	0%
Subtotal Beds	1466	-1%

Section 2: Summary of Provincial Strategy / Alignment of IHSP to Strategy

As partners in planning for the necessary improvements to health care in Ontario, the LHINs and the Ministry of Health and Long-Term Care each play important roles. The ministry sets and shares its strategic vision and priorities. Within their IHSPs, the LHINs align with the ministry's strategic directions, and at the same time set additional priorities to address local issues.

Like other LHINs, the Erie St. Clair LHIN's IHSP 2010-2013 supports ministry priorities to promote equitable access to health and health care for all Ontarians, and improve access to care in three areas:

1. Reducing wait times in emergency departments
2. Reducing the time patients spend in alternate level of care beds in hospitals
3. Supporting the Ontario diabetes strategy

The ministry has also identified mental health and addictions, and e-Health as key focus areas, both of which we currently support through our strategic priorities and activities.

Reducing Emergency Department Wait Times:

Ontarians are entitled to safe, reliable, appropriate and high-quality care when they visit an emergency department. Timely access to care can significantly improve a patient's experience, which is why reducing emergency department wait times is one of the Ontario government's top health priorities.

Experience tells us that a backlog in one area of the health system can result in delays in many other areas. To achieve shorter emergency department wait times, LHINs need to improve the efficiency of care delivery across the entire health system. We know that patients with non-urgent or less urgent needs account for about half of all emergency department visits, so we need to build care capacity within the community so people can access appropriate care outside emergency departments.

Under the ministry's direction, LHINs are working to meet provincial targets, and publicly report emergency department wait times. (See Appendix C for ESC LHIN Wait Time Report.)

Section 2: Summary of Provincial Strategy / Alignment of IHSP to Strategy

Reducing Time in Alternate Level of Care (ALC) Beds:

When patients complete the acute care phase of their treatment in hospital, they often remain in acute care beds when they no longer need acute treatment. They need an alternate level of care – but none is available.

Close to 19% of patients currently in Ontario hospital beds are waiting for an alternate level of care opening, such as a long-term care or rehabilitation care bed. This often leads to longer wait times in the emergency department as patients wait to be admitted to the hospital.

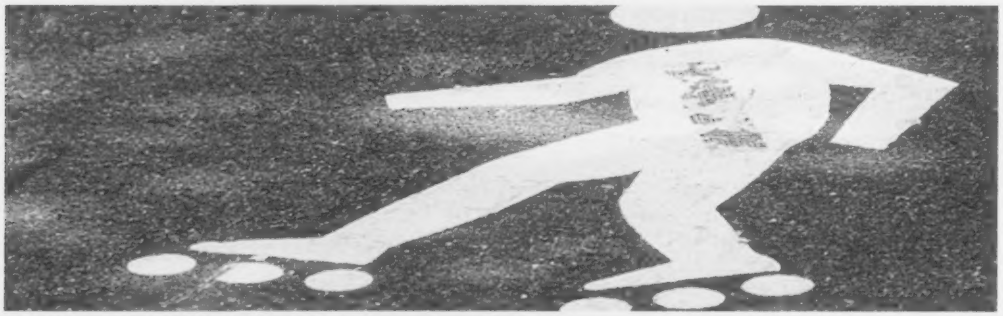
The LHINs are working with the Ontario government on a variety of initiatives that will help patients get the care they need – whether that's in a hospital, in a long-term care facility in the community or at home with supports.

Supporting Ontario's Diabetes Strategy:

Ontario's diabetes strategy will help tackle a growing – and expensive – health care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population). This number has increased by 69% over the last 10 years, and is projected to grow to 1.2 million by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion annually.

The provincial diabetes strategy will improve access to prevention programs and team-based care. The strategy includes an online diabetes registry, which is an electronic information, diagnostic, and educational tool that will enable health care providers to monitor patients living with diabetes. The registry will include best practice guidelines, alerting clinicians of the need for recurring diagnostic tests, and will give patients access to information and educational tools to help them better manage their diabetes.

The LHINs are committed to improving access to diabetes care by supporting the roll-out of the provincial diabetes strategy.



Section 2: Summary of Provincial Strategy / Alignment of IHSP to Strategy

Enhancing Mental Health and Addictions Services:

One in five Ontarians will experience a mental health or addiction problem at some time in their lives, and the cost to individuals and society is enormous. Approximately 20% of Ontarians will have a serious mental illness or harmful substance abuse issue, and between 1% and 5% will have a serious problem with gambling. Furthermore, between 15% and 21% of children and youth in Ontario have at least one mental health issue. Additionally, 10% to 25% of seniors experience mental health disorders. The cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. Investing in actively supporting people to stay mentally healthy saves money. Every dollar spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.

The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province's strategy looks beyond health to include mental health and addictions services funded by other provincial ministries.

The LHINs will implement the provincial mental health and addictions strategy, helping to create a system that provides everyone who needs care with equitable access to safe, respectful and effective services.

Building on an e-Health Framework:

In March 2009, the Ontario government released a provincial e-Health strategy, which focuses on diabetes management, medication management, and wait times. Through information technology investments such as a diabetes registry and electronic health records, the ministry aims to improve access to information and support the delivery of high quality health care for patients across the province.

The Erie St. Clair LHIN's Health Care Vision:

A health care system that helps people stay healthy, delivers good care to them when they are sick and will be there for their children and grandchildren.

Section 3: ESC LHIN's Vision for the Local Health Care System

Principles:

This vision for the Local Health Integration Networks is set out in the preamble of the Local Health System Integration Act (LHSIA), 2006, through the definition of essential principles that are intended to guide the implementation of community engagement, planning and integration functions, and the development of the Integrated Health Service Plan. These principles are as follows:

Community Engagement:
Health needs and priorities are best developed when the community, health care providers and the people they serve provide input to support the decision-making process.

Co-operation, Co-ordination and Integration:
Communities, health service providers, Local Health Integration Networks and the government must work together to reduce duplication and better co-ordinate health service delivery.

Equity and Diversity:
Communities are made up of individuals from diverse cultures, beliefs and lifestyle choices. The LHINs should, whenever possible, commit to equity and respect for diversity in communities, including respecting the requirements of the French Language Services Act in planning for and serving Ontario's French-speaking community. The LHSIA further sets out requirements for LHINs regarding relationships with and recognition of Aboriginal Peoples.

Accountability and Transparency:
The health system is governed and managed in a way that reflects the public interest and that promotes efficient delivery of high quality health services to Ontarians.

Sustainability:
An integrated health system will deliver health care services that people need now and in the future. LHINs plan, integrate and fund health services, including services from hospitals, long-term care homes, community support services, addiction and mental health services, community health centres and Community Care Access Centres. LHINs use the authority described in the LHSIA for the purpose of providing for an integrated health system to improve the health of Ontarians through better access to health services, co-ordinated health care and effective and efficient management of the health system at the local level. All activities and decisions undertaken by LHINs reflect this purpose and must be consistent with their IHSP.

Section 3: ESC LHIN's Vision for the Local Health Care System

Developing the IHSP:

The IHSP is defined in LHSIA as the local strategic plan intended to integrate the local health system. The Erie St. Clair LHIN's Integrated Health Service Plan is the public presentation of our vision, priorities and strategies and steps to implementation for the three-year period starting in April 2010. This IHSP establishes some of the building blocks for success and communicates the priority areas that will guide our LHIN activities over the next three years. The IHSP also demonstrates our approach to integrated planning and integration for the local health system through the following principles:

1) Community Engagement
Community engagement, along with substantial demographic and population health status data analyses, as well as health system use and performance data analyses, forms the basis from which the ESC LHIN created our IHSP. By understanding relationships and needs in the region and by listening to the community, we identified important local issues. An understanding of the complex relationships and circumstances within our local health care systems helped provide us with a clear rationale for our plans and proposed actions.

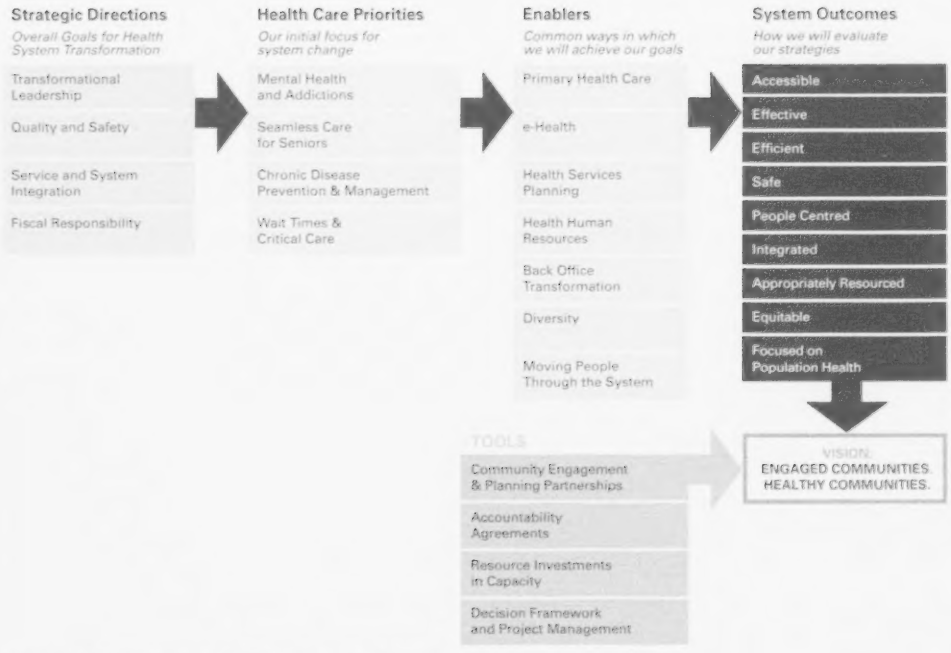
2) Foundation for Future Plans
The IHSP is the cornerstone on which LHIN decisions and plans are built over the ensuing three-year period. Even though components of our IHSP may change, the analysis we performed during the development of the IHSP provides strong and clear direction for ESC LHIN activities. It includes measurable targets, such as those outlined in the Ministry of Health and Long-Term Care-LHIN Accountability Agreement (MLAA), so that we can monitor and report on our success to the community.

3) Priorities for Integration
The IHSP communicates key integration opportunities and local priorities for health system integration. The ESC LHIN supports and actively encourages integration as opportunities arise. Priorities for integration are aligned with the ministry's strategic plan.

4) Demonstrates Achievement of Ministry Strategic Directions
The ESC LHIN works together with the ministry to ensure that we are moving toward provincial goals and objectives, as well as local goals and objectives. The Ministry of Health and Long-Term Care's 10-year strategic plan sets high level direction for Ontario's health care system. Through our IHSP, the ESC LHIN shows how we are guided by the ministry's strategic plan through specific goals for our communities.

5) Optimizing Available Resources
Priorities and strategies developed by the ESC LHIN recognize resource constraints and plan within a defined funding envelope. Our IHSP considers analyses of local resources issues and opportunities for development on a variety of strategic areas.

Section 3: ESC LHIN's Vision for the Local Health Care System



The IHSP within the Provincial Context:

The IHSP is one of several plans, agreements and actions which together comprise the provincial planning cycle. They include the activities not only of the LHINs themselves, but also of government, and health service providers. These include:

Accountability Agreements: both between the Ministry of Health and Long-Term Care and the LHINs and between the LHINs and health service providers

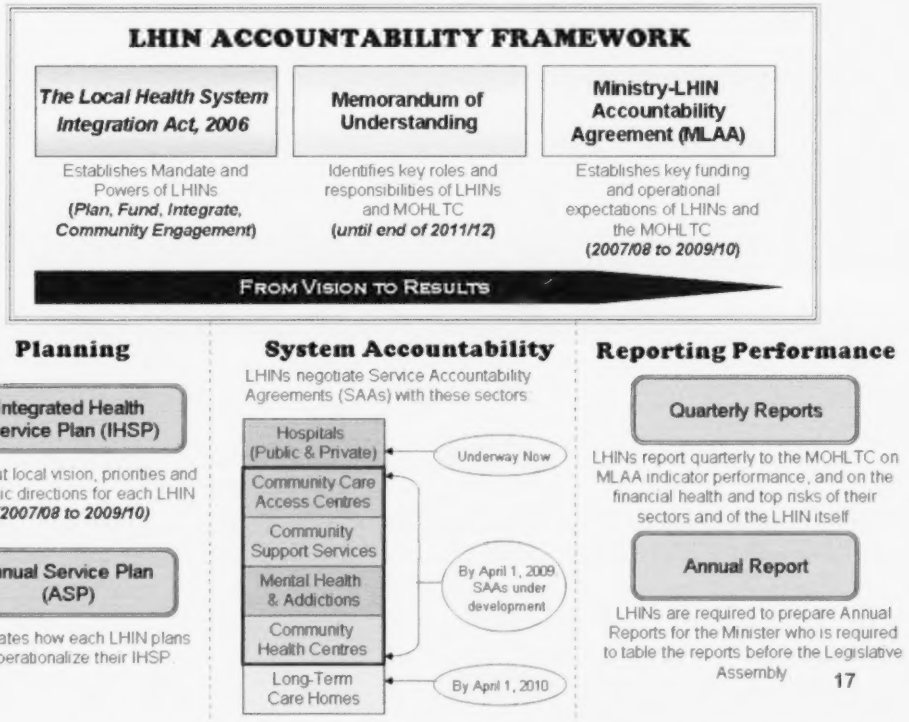
Annual Planning Submissions: by the health service providers to the LHINs and from the LHINs to the Ministry of Health and Long-Term Care

Results-Based Planning (RBP): the Ontario government's budgeting and planning cycle has multiple milestones for gathering information and reporting to the public

Ministry of Health and Long-Term Care's Strategic Plan: the first long-range view of ministry priorities and directions over a 10-year span

The Ministry of Health and Long-Term Care follows an annual planning cycle. Each LHIN also has a planning process, as does each health service provider. The Ministry of Health and Long-Term Care's Strategic Plan is intended to drive and align other planning activities in the system and defines the long-term priorities for the LHINs' IHSPs.

Section 3: ESC LHIN's Vision for the Local Health Care System


LHIN ACCOUNTABILITY FRAMEWORK
The Local Health System Integration Act, 2006
Establishes Mandate and Powers of LHINs (Plan, Fund, Integrate, Community Engagement)
Memorandum of Understanding
Identifies key roles and responsibilities of LHINs and MOHLTC (until end of 2011/12)
Ministry-LHIN Accountability Agreement (MLAA)
Establishes key funding and operational expectations of LHINs and the MOHLTC (2007/08 to 2009/10)
FROM VISION TO RESULTS
Planning
Integrated Health Service Plan (IHSP)
Sets out local vision, priorities and strategic directions for each LHIN (2007/08 to 2009/10)
Annual Service Plan (ASP)
Articulates how each LHIN plans to operationalize their IHSP
System Accountability
LHINs negotiate Service Accountability Agreements (SAAs) with these sectors
Hospitals (Public & Private)
Community Care Access Centres
Community Support Services
Mental Health & Addictions
Community Health Centres
Long-Term Care Homes
Underway Now
By April 1, 2009 SAAs under development
By April 1, 2010
Reporting Performance
Quarterly Reports
LHINs report quarterly to the MOHLTC on MLAA indicator performance, and on the financial health and top risks of their sectors and of the LHIN itself
Annual Report
LHINs are required to prepare Annual Reports for the Minister who is required to table the reports before the Legislative Assembly
17

Section 4: Overview of the Erie St. Clair Local Health Care System

This section provides an overview of the Erie St Clair local health system, including information on the populations served, their health status and health behaviours. The section concludes with an explanation of the many factors that impact the health of the population. Where possible, the analysis includes a comparison of the following planning areas: Chatham-Kent, Windsor/Essex, Sarnia/Lambton, the Erie St. Clair LHIN and the province of Ontario. This information is widely used by health care providers and planners to set priorities and allocate resources to effectively address needs, service gaps and develop strategic plans. (For a more comprehensive profile of the local health system, refer to Appendix B – Population and Service Profile for Erie St. Clair LHIN.)

Section 4: Overview of the Erie St. Clair Local Health Care System

Population Profile:

Erie St. Clair, the southernmost LHIN, encompasses Essex County, the Municipality of Chatham-Kent and Lambton County and is home to 649,000 people, representing 5.2% of the population of Ontario. During the years 2001-2006, the population of Erie St. Clair increased, on average, 0.9% each year while the population of Ontario increased by 1.6% annually. Of the total Erie St. Clair population, 17.2% live in Chatham-Kent, 62.4% in Essex County and the remaining 20.3% in Lambton County. Compared to Ontario as a whole, Erie St. Clair has a larger rural population (5.4% larger than the province). Population density is also considerably lower in Erie St. Clair (approximately 73 fewer people per square kilometre) than in the province as a whole.

In total, the Erie St. Clair population increased by 4.6% between 2001 and 2006. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30-34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities. It is projected that between 2010 and 2020 the population of Erie St. Clair will grow by 3.9%. At the county level, the population of Chatham-Kent is expected to decline by 1.1% while Sarnia/Lambton and Windsor/Essex are expected to grow by 1.8% and 5.9% respectively. During the same time period, it is projected that the population of Ontario will grow by 12.0%.

Although there has been a slight increase in the proportion of the population who are immigrants or visible minorities (0.8% and 2.0% growth respectively), Erie St. Clair continues to be notably less diverse than the province. Of the total Erie St. Clair population, 3.3% identify as francophone (i.e., claim French as their mother tongue) which is slightly lower than for Ontario as a whole. Essex consistently has a greater proportion of the population who are immigrants, visible minorities or francophone when compared to Chatham-Kent or Sarnia/Lambton.

The proportion of the population who identify themselves as Aboriginal in Erie St. Clair has increased slightly since 2006, and is now 0.4% higher than for the province. The proportion of Aboriginal individuals is highest in Sarnia/Lambton at 4.6%, which is 2.6% higher than in Ontario as a whole, and lower in Chatham-Kent (2.5%) and Windsor/Essex (1.6%).

The proportion of families with children headed by one parent has increased slightly to 25.4% and is now 0.8% higher than for Ontario. The prevalence of one-parent families is similar across all of the counties.

The population of Erie St. Clair has less formal education compared with the province as a whole. Approximately half of the population (50.6%) has completed post-secondary education while 21.7% of the population does not have a certificate, degree or diploma. The levels of formal education are highest in Sarnia/Lambton and lowest in Chatham-Kent.

Section 4: Overview of the Erie St. Clair Local Health Care System

Table: Erie St. Clair Population Demographics based on 2006 Canadian Census

	Chatham-Kent	Essex	Lambton	Erie St. Clair			Ontario
Population Demographics	**2006**	**2006**	**2006**	**2006**	**Change 2001-2006**	**Difference from Ontario**	**2006**
Population							
Total Population	108,590	393,400	128,205	630,196	4.6%	-	12,160,287
65-74 years	8.2%	6.9%	8.7%	7.5%		7.1%	
75 years+	7.7%	6.4%	8.2%	7.0%		6.4%	
Language							
% population with English mother tongue	87.5%	73.8%	89.9%	79.4%		9.6%	69.8%
% population with French mother tongue	3.0%	3.6%	2.5%	3.3%		-1.1%	4.4%
Immigration & Ethnic Origin							
% of population who are immigrants	10.1%	22.4%	11.6%	18.1%		-10.2%	28.3%
% of population who arrived within last 5 years	1.0%	3.9%	0.8%	2.8%		-2.0%	4.8%
% of population who are visible minorities	4.3%	14.2%	2.7%	10.1%		-12.7%	22.8%
% of population of Aboriginal identity	2.5%	1.6%	4.6%	2.4%		0.4%	2.0%
Labour Force							
% of population age 15+ in Labour Force	65.8%	64.8%	64.3%	64.8%		-2.3%	67.1%
Education							
% of population without certificate, degree, diploma	27.4%	21.0%	18.9%	21.7%		3.0%	18.7%
% of population age 25+ who completed post-secondary education	44.9%	51.0%	54.0%	50.6%		-6.2%	56.8%
Family							
% of families with children, headed by one parent	25.9%	25.2%	25.4%	25.4%		0.9%	24.5%
Housing							
% of non-owned private dwellings	26.9%	24.5%	24.4%	24.9%		-4.1%	29.0%
Low Income							
Proportion of population with low income	11.9%	13.1%	9.4%	12.2%		-2.5%	14.7%

Source: Statistics Canada, 2006 Census, www.statcan.gc.ca

Section 4: Overview of the Erie St. Clair Local Health Care System

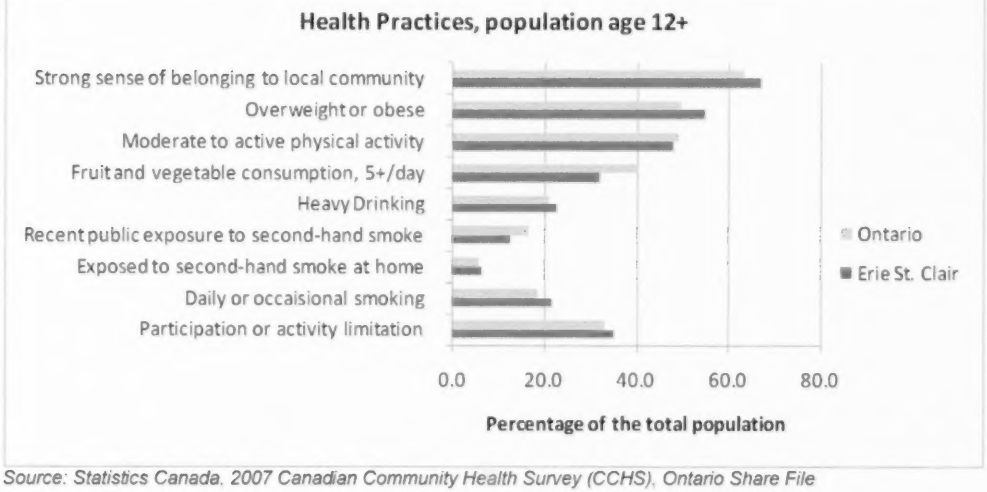
From 2001 to 2006, the unemployment rate in Erie St. Clair decreased slightly to 7.5%, which is higher than the 6.4% unemployment rate for the rest of Ontario. Unemployment was highest in Essex (7.9%) and lowest in Sarnia/Lambton (6.5%). However, with the dramatic changes that occurred in the Canadian economy between 2008 and 2009, the employment situation in Erie St. Clair has shifted. In June 2009, the unemployment rate in Windsor/Essex increased significantly to 12.8% and was considerably higher than the provincial average of 9.4%.The localized unemployment impact on the Municipality of Chatham Kent is also significant.

Essentially, the economic challenges in Canada have had a disproportionate impact on the Erie St. Clair LHIN. It is anticipated that the economic and employment situation will result in increased need and demand for social services and mental health and addiction services within the Erie St. Clair LHIN. In summary, the Erie St. Clair LHIN has real concerns with the pending impact of the economic situation on the service demand and performance implications within the local health care system.

Health of the Population:

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability. Relative to the rest of the province, residents of Erie St. Clair report higher rates of smoking, alcohol consumption and obesity, and lower rates of physical activity and healthy eating (see Chart 1 below). These risk factors place the residents of Erie St. Clair at a higher risk for developing chronic conditions, especially diabetes.

Chart 1: Health Practices, Population Age 12+



Source: Statistics Canada. 2007 Canadian Community Health Survey (CCHS), Ontario Share File

Section 4: Overview of the Erie St. Clair Local Health Care System

The point of access for most medical care is through a primary care physician. The majority of people in Erie St. Clair have a regular primary care physician (89.1%) with 80.3% having had at least one contact with a physician in the past year. The rate of influenza immunization in Erie St. Clair is higher than for the province as a whole.

Health status information indicates that life expectancy among males and females in Erie St. Clair is lower than life expectancy for Ontario overall. Since 2005, female life expectancy at birth increased by 0.6 years for both Erie St. Clair and Ontario. During the same period, male life expectancy at birth in Erie St. Clair increased by 1.3 years. Between 2001 and 2005, male life expectancy in Erie St. Clair increased at a higher rate than female life expectancy.

Table: Life Expectancy in Erie St. Clair

	Erie St. Clair			Ontario	
	2005	Change since 2001	Difference from Ontario	2005	Change since 2001
Education					
Life Expectancy at Birth, Males, in years	77.5		-1.1	78.6	1.1
Life Expectancy at Birth, Females, in years	81.8		-0.9	82.7	0.6

Chronic conditions place a high burden on the health care system and reduce the quality of life of those who have one or more of these conditions. The table below shows that compared with Ontario, Erie St. Clair has higher rates of the following chronic conditions (from highest to lowest): arthritis, hypertension, asthma, anxiety disorder, diabetes and mood disorder. For all age groups, arthritis and hypertension are the most common of the selected chronic conditions. It was further determined that Erie St. Clair residents over the age of 65 have the highest occurrence rates for all of the selected conditions.

Table: Prevalence Rates for Selected Chronic Conditions, Erie St. Clair and Ontario, 2007

	Erie St. Clair				Ontario		
	2007	2005	Change since 2005	Difference from Ontario	2007	2005	Change since 2005
Education							
Arthritis	20.9	21.5		4.5	16.4	17.2	
Hypertension	17.3	17.5		0.9	16.4	15.4	
Asthma	10.4	8.6		2.2	8.2	8.0	
Anxiety disorder	7.7	4.7		0.8	6.9	4.3	
Diabetes	7.3	5.5		1.2	6.1	4.8	
Mood disorder	6.5	8.0		0.9	5.6	6.0	
Heart disease	4.6	5.8		-0.4	5.0	4.8	
Cancer	1.9	1.4		0.4	1.5	1.5	-
Stroke	1.4	1.4	-	0.1	1.3	1.1	

Source: Statistics Canada, 2007 Canadian Community Health Survey (CCHS), Ontario Share File

Health Service Providers and Budget in Erie St Clair LHIN:

In the Erie St. Clair LHIN, there are a total of 87 health service providers offering 111 programs (for a more comprehensive inventory of the local health system refer to Appendix D – Assessment of Services, Resources and Programs), including:

- 35 Long-Term Care Facilities
- 34 Community Support Service Organizations
- 13 Mental Health Organizations
- 7 Addictions Service Providers
- 7 Supportive Housing Providers
- 5 Hospitals
- 4 Community Health Centres
- 3 Addiction Programs
- 2 Acquired Brain Injury Programs
- 1 Community Care Access Centre

A significant number of ministry-funded services do not fall under the LHIN mandate. These include most physician services, ambulance services, public health, drug benefits, laboratories and independent health facilities.

Section 4: Overview of the Erie St. Clair Local Health Care System

For 2009-10, the Erie St Clair LHIN's health system budget totaled $933.4 million. Hospitals account for the majority of spending, at 64.1% of the overall budget or a little over $598 million (see table below). In 2008-09 the budget for our health service programs was only 4.43% of provincial health program expenditures ($21.07 billion). Compared to other LHINs, Erie St. Clair LHIN operations receive less funding per capita than the provincial average. This shortfall is made up through our use of regional health care services in London and Toronto. Erie St. Clair residents represent approximately 5% of Ontario's population.

Table: Erie St. Clair LHIN 2009/10 Funding by Major Program Area

	ESC LHIN (as of June 30/09)	% of Total
ABI (Acquired Brain Injury)	$1,078,200	0.1%
Addictions	7,780,400	0.8%
ALSSH (Assisted Living Services in Supportive Housing)	5,293,300	0.6%
CCAC	104,753,800	11.2%
CHC	17,134,300	1.8%
CMH (Community Mental Health)	27,415,400	2.9%
CSS	14,269,400	1.5%
Hospitals	598,374,000	64.1%
Long-Term Care	157,170,000	16.8%
Municipal Grants	163,000	0.0%
Total	$933,431,800	
% of Ontario	4.43%	

Summary of Key Findings:

Future Demographics, Projections and Trends:

The Erie St. Clair population is growing at a slower rate, is more rural and has less population density than the population of Ontario as a whole. Erie St. Clair has a growing senior population and a decreasing younger population (i.e., 0-14 and 25-49 age groups), leading to a higher dependency ratio as compared to the province. Although Erie St. Clair continues to be less diverse than Ontario it is important to consider the unique health care needs of francophone and Aboriginal residents.

Section 4: Overview of the Erie St. Clair Local Health Care System

Economic Challenges:

The economic challenges experienced in 2008 and 2009 have resulted in a disproportionately high unemployment rate compared to the provincial average. This may be because the population of Erie St. Clair has less formal education compared to the province as a whole. The economic situation may result in an increase in the proportion of the population considered low income. This may increase pressures on social services and mental health and addictions services. (See Appendix C – SWOT Analysis Results.)

Health Status and Chronic Conditions:

The residents of Erie St. Clair believe that they are healthier than they actually are. Erie St. Clair residents have a lower life expectancy rate, and a higher age-standardized mortality rate compared to the province. They also have a higher rate of potential years of life lost. The Erie St. Clair population has more chronic diseases than Ontarians overall and, based on many risk factors (smoking, alcohol misuse, physical inactivity, poor diet and obesity), are at risk of developing more chronic conditions, especially diabetes. There is a need to consider how cancer, diseases of the circulatory system, diseases of the nervous system and mental health conditions can be managed more effectively to reduce mortality and illness and death.

Assessment of Service Utilization:

Opportunities exist to improve both access and use of emergency departments across Erie St. Clair. Although, the Erie St. Clair LHIN performed just above the provincial targets for emergency department length of stay, there are specific opportunities within the region to decrease both the low acuity and high acuity length of stay in hospital emergency departments. For the small hospitals across the ESC LHIN, additional pressures are associated with the type of emergency department cases. Specifically, in 2007/08, non-urgent and deferrable cases represented over 70% of the total visits to small emergency departments.

From a patient flow perspective, providing care at the right place and at the right time continues to be a system challenge across the Erie St. Clair LHIN. Regional opportunities exist to address the growing percentage of alternate level of care days. In 2008/09, across the Erie St. Clair LHIN, the operational and financial impacts of this system challenge were clearly evident. Within our hospitals, approximately 11% of acute care beds, 34% of complex care beds and 7% of rehabilitation beds were occupied by patients requiring a different level of care in a different setting. The estimated system cost associated with this alternate level of care issue is approximately $32 million.

Section 4: Overview of the Erie St. Clair Local Health Care System

Although, by 2011, additional long-term care beds will be in place across the Erie St. Clair LHIN, the challenges associated with the demand for long-term care and use of other aging at home supports still need to be addressed. In 2008/09, the average time for long-term care placement exceeded the target (in some regions, by more than 100%). With a growing senior population, opportunities exist to ensure that Erie St. Clair residents have access to the most appropriate services and that improvements are made in the co-ordination and use of all aging at home supports (e.g., long-term care homes, retirement homes, staying at home with community support services).

With the mounting economic challenges, it is important that the Erie St. Clair LHIN address opportunities to improve access to mental health and addictions services. The trends are clear both in our hospitals and in the community. In our hospitals, the majority of mental health and addictions emergency department visits and inpatient cases are associated with several key diagnoses – neuroses, stress-related disorders, mood disorders, mental and behavioural disorders due to psychoactive substance use and schizophrenia. In the community, mental health and addictions programs, such as problem gambling, substance abuse, concurrent disorder, early intervention and crisis, have all seen an increase in the number of individuals seeking support.

Section 5: Framework for Planning

Local Health Integration Networks are legislated not-for-profit organizations that are responsible for planning, integrating and funding local health services across the province. Since a key requirement of each LHIN is to produce a comprehensive Integrated Health Service Plan (IHSP), which states the main strategic directions that they will be taking over a three-year period, the Ministry of Health and Long-Term Care and the LHINs created a roadmap document that sets out the basic structural components of the IHSP. The ministry has also been instrumental in working with LHINs to establish some key provincial priorities that the LHINs must address in carrying out their mandate (e.g., emergency department, alternative levels of care, diabetes, mental health and addictions).

Within each LHIN region, there is flexibility to address local needs and unique concerns through the advancement of local planning principles and prioritization criteria needed for effective decision-making. Once the priorities have been established, the LHINs work closely with local health care providers and community members to develop annual and 90-day Action Plans, and implement and monitor progress toward achieving these goals for their local area. This section of the report describes the Erie St. Clair LHIN IHSP Planning Framework. This includes planning principles, priority decision-making criteria, and how we will monitor the results of the action plans using a new conceptual framework, the Triple Aim approach, developed by the Institute for Healthcare Improvement (IHI) based in Cambridge, Massachusetts.

Section 5: Framework for Planning

Planning Principles:

The health care system is very complex. It is a mix of patient needs and the services that are available to meet those needs. Therefore, changing and improving the health care system is an evolutionary process that requires addressing a number of issues. It is not enough to establish our priorities based on data alone. We also need to reflect on and apply the following concepts in our decision-making processes:

- System Pressures – Does it deal with the burning issues of the day?
- System Thinking – Does it look at impact, risk and outcomes for those accessing or providing health care services across Erie St. Clair?
- Action Oriented – Is it achievable and how can we make it happen?
- Resource Constraints – What are the barriers to making positive change?
- Focus on the Patient – How do we improve the patient experience and maximize the benefit to consumers across Erie St. Clair?

Prioritization Criteria:

The Erie St. Clair LHIN developed a decision-making framework as a tool to guide decision-making, and also assist in the prioritization of proposed directions and initiatives. With clear and objective criteria established, this decision-making framework allowed the Erie St. Clair LHIN to effectively evaluate opportunities that emerged from the environmental scan and community engagement process.

The framework has nine attributes that collectively serve as the prioritization criteria. It is based on The Decision-Making Framework for the Central East LHIN and on the attributes of a high performing health system as defined by the Ontario Health Quality Council.

Section 5: Framework for Planning

Decision-Making Framework

Attribute	Description
Strategic Alignment and Accountability	Does the proposed direction/initiative support and advance the achievement of Erie St. Clair LHIN strategic priorities, goals and accountabilities?
Accessible	Will the proposed direction/initiative help ensure that people will be able to get the right care at the right time in the right setting by the right health care provider?
Effective	Will the proposed direction/initiative help ensure that people receive care that works and is based on the best available scientific information?
Safe	Will the proposed direction/initiative expose people to harm? Will the initiative reduce the likelihood of accidents or mistakes when people are receiving care?
Person-Centred	Will the proposed direction/initiative offer services in a way that is sensitive to an individual consumer's needs and preferences?
Focus on Population Health	Will the proposed direction/initiative help prevent sickness and improve the health of the population served by the Erie St. Clair LHIN?
Equitable	Will the proposed direction/initiative provide the same access and quality of services to people regardless of who they are or where they live?
Integrated	Will the proposed direction/initiative improve the extent to which all parts of the health system are organized, connected and work with one another to provide high quality care?
Appropriately Resourced (Sustainable)	Will the proposed direction/initiative help ensure that the health system has enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs?

Triple Aim Framework and IHSP:

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action. IHI advanced a new planning design intended to simultaneously accomplish three critical objectives, or what they call the "Triple Aim":

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability) and,
- Reduce, or at least control, the per capita cost of care

Section 5: Framework for Planning

The IHI's Triple Aim Initiative aligns closely with the desired outcomes of the LHIN IHSP namely by transforming the health care system by focusing on three dimensions of care - improving the health of the population, enhancing the patient experience and reducing, or at least controlling, the per capita cost of care. This approach also encourages its members to develop partnerships in their communities and involve other health care organizations, community groups, patients and their families in a co-ordinated effort to reach these goals.

The framework provides the LHIN with a tool to evaluate its progress and success across a variety of areas relevant to the overall aims of the initiative. The ESC LHIN will apply the Triple Aim concept and processes in it three-year planning horizon. (See Appendix H for more details on the Triple Aim approach.)

Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System

In order to achieve the mission, vision and MLAA targets, the ESC LHIN will focus its strategic attention on established priorities, identified populations and targeted goals.

This section provides information on the specific populations that will be targeted over the next three years (for each priority area), the specific goals that the ESC LHIN will pursue through the Triple Aim process, and 90-day action planning.

5 Strategic Directions, in review:

Improved outcomes in alternate level of care

Improved outcomes in emergency department care

Improved outcomes in diabetes management (chronic disease management)

Improved outcomes in mental health and addictions

Improved outcomes in rehabilitation care and interventions

WWW.ERIESTCLAIRLHIN.ON.CA

Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System

Alternate Level of Care (ALC)

Priority Populations

- Patients admitted in Complex Continuing Care
- Geriatric mental health clients
- Post -acute (convalescent) clients
- Rehabilitation (long and short-term) clients
- Bariatric patients
- Patients with pre-existing infectious diseases
- Hospitalized (acute and post-acute medicine and surgical) patients that could functionally benefit from an ambulation intervention
- Frequently readmitted chronic disease patients (CHF, COPD)
- Elderly/seniors with care needs in excess of 2 hours/day, but who could still remain in their home with increased care

System Specific Goals

- Ensuring appropriate community care and affordable discharge options (including end of life care)
- Maximize functional conditioning of patients over the age of 60
- Improve ED wait times for CTAS 1,2, and 3 levels
- Improved placement time for long-term care home placement for inpatients and community clients
- Develop a fully implemented falls prevention program within the long-term care communities
- Creation of effective standardized educational programs for seniors with respect to services, supports and programs available to assist them in either: a) staying at home, b) transitioning to rest/ retirement home, or c) the transition to long-term care
- Reduce inpatient hospital fall rates for all patient units
- Reduction in acute LOS for chronic disease populations

Emergency Department (ED) Care

Priority Populations

- Admitted patients awaiting transfer from ED to acute beds
- Patients referred to emergency department due to lack of urgent testing/consultation in the community or lack of after-hours primary care coverage
- High intensity of care patients requiring increased staffing and treatment resources
- Patients with CTAS level 3, 4 & 5
- Patients with wound care/soft tissue infections
- Patients with known MRSA+, VRE+-infection control risk
- Patients requiring stabilization of their acute mental health issues

System Specific Goals

- Streamlined mental health services that are seamless between community providers and hospital
- Enhanced referral for unattached patients to existing primary care providers
- Enhancing adequate after-hours/weekend/holiday coverage of primary care practitioners
- Improved access to primary care assessments in nursing homes/long-term care facilities
- Improved access to Intensive Care Unit (ICU) / Coronary Care Unit (CCU) beds
- Improved response rate to lower acuity patients within the ED setting
- Reduced ED visits and readmission for chronic disease management patients
- Determine appropriate care pathway for patients with known community-acquired infections

Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System

Diabetes

Priority Populations

- Individuals with diabetes who do not have a primary care provider
- Seniors (65+) with diabetes
- Women with gestational diabetes
- Individuals who suffer from mental illness and diabetes
- First Nations people with diabetes
- Ethnic populations who have diabetes
- Rural or geographically isolated people with diabetes who experience transportation challenges
- Pediatric individuals with diabetes

System Specific Goals

- Improved/ streamlined co-ordination across service providers (vertical and horizontal integration) within LHIN sub regions
- Improved system navigation within LHIN sub regions
- Reduce avoidable emergency department visits for diabetes from baseline measures
- Improved, shared and standardized educational programming (e.g., best practices, ongoing, professional development)
- Expand existing care capacity (primary care specifically)
- Optimize wait times for diabetes services
- Improved and timely access to specialized consultations
- Increased compliance of health care practitioners with existing clinical practice guidelines
- Improved screening of identified higher risk populations

Mental Health

Priority Populations

- Concurrent Disorders (mental health and addictions) clients
- Early intervention clients (newly identified youth with psychotic disorders/mental illness)
- General population who are unemployed, or at risk, and those still working but who are below the poverty line
- Mental health clients without primary care providers
- Geropsychiatry - (psycho geriatric) populations
- Crisis population
- Adults with mood disorders
- Seriously mentally ill adults

System Specific Goals

- Develop alternatives to current dependencies on emergency department services
- Reduced admissions to inpatient mental health services
- Provide community based care to elderly adults with mental health problems to prevent or delay admission to hospital or placement in a long-term care facility
- Increase stabilized housing programs for all targeted priority populations
- Develop strategies with selected partners to lessen the unemployment effect on the localized economy

Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System

Addictions

Priority Populations

- Adults with an opiate dependency
- Youth with addictions issues
- Seniors 65+ with addictions issues

System Specific Goals

- Increased access to withdrawal management services
- Reduced reliance on primary care, ED and inpatient services for withdrawal management and addiction services
- Increased capacity (service volumes) and reduced wait times (referral to service initiation) of outpatient services for opiate dependent adults, youth and seniors
- Improved integration and revised delivery models for services in order to appropriately meet patient needs across the lifespan (youth, adult and senior)
- Ensure that a continuum of addiction services are available to opiate dependent adults youth and seniors within the Erie St. Clair region

Rehabilitation & Interventions

Priority Populations

- Frail individuals over the age of 65 with multiple chronic conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cardiovascular disease (CAD), musculoskeletal conditions (arthritis, osteoporosis) and/or progressive neurological conditions (dementia, alzheimer's, multiple sclerosis, parkinson's disease)
- Complex disability patients (stroke)
- Individuals with chronic respiratory diseases, heart failure
- Neurological, vascular and orthopedic populations
- Frail individuals over the age of 65 with reduced mobility, balance, endurance and strength , weight loss, evidence of depression, dementia, delirium, and/or incontinence

System Specific Goals

- Improve access to outpatient rehab services and day programs for stable patients not requiring an inpatient bed
- Facilitate appropriate use of inpatient rehab beds
- Improve activation for the complex inpatient geriatric population with low intensity long duration rehab services
- Provide access to a pulmonary rehabilitation program service delivery model
- Improve flow through by increased patient and family capacity to self-manage along the continuum
- Create/expand/enhance sub-acute, primary care and community partnerships to facilitate guided transition to community
- Create/expand/enhance feedback linkages from community to primary health to maintain successful healthy living in the community, avoiding ED visits and ED-acute care readmissions

Section 6: Priorities, Strategic Directions / Goals for the Local Health Care System

Complementary (Enabling) Strategic Projects

Four separate objectives have also been established for examination and action within the three-year period of the IHSP. These objectives will drive vertical and horizontal integration between LHIN-funded services and increase access, quality, cost effectiveness and system co-ordination. The objectives follow:

Diagnostic Imaging, Laboratory and Pharmacy Services Examination and Integration

Goal: The ESC LHIN will establish a method to inventory, standardize and co-ordinate diagnostic imaging, laboratory and pharmacy services.

Rationale: Considerable variation exists in diagnostic imaging, laboratory and pharmacy services in Erie St. Clair. An examination and co-ordination of the functions will help the ESC LHIN determine requirements, and improve capacity and cost-effectiveness.

Complex Continuing Care (CCC beds) Program Standardization

Goal: The ESC LHIN will establish a mechanism to standardize care processes and potentially re-engineer the system in order to improve functional outcomes.

Rationale: Considerable variation also exists within the CCC bed complement in Erie St. Clair. CCC beds are considered a key complementary resource to achieving ESC LHIN aims and are strategic to serving the needs of the ESC LHIN's vulnerable populations.

System Clinical Services Plan

Goal: The ESC LHIN will develop a clinical services plan in order to guide the future orientation of health services in the region. A clinical services plan for the system will also be a key driver in long term sustainability.

Rationale: A clinical services strategic plan will augment health human resources recruitment, capital planning and service designations. The plan will help the local system move to the next level of performance.

Health Human Resources

Goal: To complement the clinical services plan, the ESC LHIN will resume its efforts to establish partnerships with stakeholder agencies in order to develop strategies to meet health human resource requirements.

Rationale: As identified in the original IHSP, health human resources is a key pillar of the local health care system. Population health care service needs will grow and evolve, and adequate health human resources are needed to address those needs.

Section 7: Rationale for Strategic Directions/Goals

The Erie St. Clair LHIN analysis thoroughly considered information gathered on the health needs of the population (e.g., the most common chronic diseases and related health issues), trends in how the system is being used, what the main system pressures are, feedback collected through the community engagement processes, alignment with the Ministry of Health and Long Term Care's Provincial Priorities, and ESC LHIN Board input.

Improved Outcomes in Emergency Department Care:

In the Erie St. Clair LHIN (and Ontario generally), the emergency department has all too often become the default portal through which many consumers gain access to health care. The resulting ED congestion is an indicator of how the entire health system is performing, telling us how well our family health care, community care, mental health, and hospital programs are working to serve patients. Inappropriate use of the ED is a waste of an expensive, limited resource. Information obtained from Ontario's Emergency Department Reporting System data indicated the following in 2009:

- Nine out of 10 people with complex conditions requiring more time for diagnosis, treatment or admission to a hospital bed spent up to 14.6 hours in the ED - this is well above the provincial access target of eight hours.
- Nine out of 10 people with minor or uncomplicated conditions requiring less time for diagnosis, treatment and observation spent up to 4.8 hours in the ED, which is slightly higher than the provincial access target of four hours.

In Erie St. Clair, the high volumes of non-urgent (CTAS 4) and deferrable (CTAS 5) visits to emergency departments of small hospitals reflect a lack of timely access to primary care services. For instance, the top conditions associated with ED visits that could be managed elsewhere (i.e., visits for conditions that could be treated in alternative primary care settings) are upper respiratory infections, bladder infections, ear infections and eye infections. In Sarnia/Lambton and Chatham-Kent, the rate of emergency department visits that could be managed elsewhere is more than double the overall rate across the ESC LHIN.

Section 7: Rationale for Strategic Directions/Goals

Improved Outcomes in Alternate Level of Care (ALC):

Every day, people in Erie St. Clair are receiving care in the wrong location. From 2005/06 to 2007/08, the number of ALC days increased by 30%. In 2008/09, across the ESC LHIN, approximately 11.4% of acute care beds, 34.1% of complex care beds and 7.5% of rehabilitation beds were occupied by ALC patients. For patients hospitalized with ambulatory care sensitive conditions (conditions where access to appropriate ambulatory care prevents or reduces the need for admission to a hospital), 90% of the total ALC days across the ESC LHIN were associated with three conditions: congestive heart failure, chronic obstructive pulmonary disease and diabetes.

Residents in the Erie St. Clair LHIN are waiting longer for a bed in a long-term care home. In 2008/09, the average time to long-term care placement well exceeded the ESC LHIN performance target of 53 days. Specifically, Sarnia/Lambton and Windsor/Essex had the highest median time to placement (averaging 124 days and 104 days respectively).

Further, patients are occupying emergency department space because there are no available acute care beds. In April 2009, Ontario hospitals estimated that approximately 18% of acute care beds were occupied by ALC patients (Ontario Hospital Association, 2009).

Finally, community services - such as home care, long-term care and other services including rehabilitation services - need to be prioritized and financed in such a way that they move ALC patients out of the acute care setting. In turn, this will make acute care beds available for patients who are waiting in the ED.

Improved Outcomes in Diabetes Management - Chronic Disease Management:

Compared to provincial rates, the Erie St. Clair population has higher rates of occurrence for the following chronic conditions: arthritis, asthma, diabetes, hypertension, mood disorder, chronic obstructive pulmonary disease, and heart disease. Of these conditions, the largest proportions of emergency department visits are associated with arthritis, heart disease and chronic obstructive pulmonary disease.
Furthermore, unhealthy behaviours such as smoking, alcohol misuse, physical inactivity and poor diet, positions Erie St. Clair residents at higher risk for conditions such as diabetes, circulatory diseases, and heart disease.

Section 7: Rationale for Strategic Directions/Goals

In 2005, approximately 36,000 residents of Erie St. Clair had a diagnosis of diabetes, which is 14% higher than the province of Ontario average. During the same year, there were approximately 800 acute hospital visits (9% higher than the province of Ontario) and 1500 emergency department visits (7% higher than the province of Ontario) by patients with diabetes. Looking forward at population health trends, Erie St. Clair residents will continue to be at a high risk for developing diabetes, and other associated chronic conditions, due to the high prevalence of risk factors – smoking, alcohol misuse, physical inactivity, poor diet and obesity.

Key reasons for poorer outcomes for chronic disease management in Erie St. Clair are:

- Lack of information technology to monitor and track patient care to best practices
- Lack of patient education and self-management programs
- Cost, e.g., low income residents cannot afford medications for lowering cholesterol
- Poor lifestyle choices
- Lack of timely access to primary care

Mental Health and Addiction Services:

The ministry and local communities have been planning for reform of the mental health and addictions systems for approximately 10 years.

Recurring themes and issues:

- The focus now must be on implementing reform.
- There is a need for increased funding and appropriate transitional funding.
- Services for people with a mental illness and/or addiction need to be better co-ordinated and integrated at the local level.
- More support is needed for a co-ordinated and comprehensive mental health system, which provides a continuum of care.
- Consumers need the best available access to services and medications
- There is a need to focus on accountability, measuring outcomes, evidence-based research, and evaluation.
- A service delivery model for mental health and addictions services in Ontario must be designed along with a supporting policy framework.
- Consumer/survivors and their families need meaningful participation in the reform process.
- Ontario's diverse population must be addressed during the reform process.
- There needs to be a plan for the change management process.
- An effort must be made to improve education, training, and public awareness.

Section 7: Rationale for Strategic Directions/Goals

Further, the ESC LHIN region has been extremely hard hit in the economic downturn. Mental health and addictions are areas that are traditionally underserviced and there has been an impact on emergency departments, acute settings and community resources as a result of the current economy. The data shows:

- In the emergency department, 77% of the mental health and addictions visits are associated with the following three diagnoses: neuroses, stress related and somatoform disorders, mood disorders, and mental and behavioural disorders due to psychoactive substance use.
- In the acute setting, 77% of active cases are associated with mood disorders and schizophrenia and other psychotic disorders.
- In the community, increases in new admissions indicate a growing need for problem gambling and substance abuse programs. For individuals seeking substance abuse treatment services, the top three substances identified are alcohol, cocaine and narcotics.

Finally, anecdotal information identifies that suicides and abuse events are increasing with the localized severe economic downturn.

In 2008, the ministry made a commitment to strengthen mental health and addiction services in the province, including improving wait times in emergency departments for people with mental illnesses and addictions and providing better care for people with eating disorders or early psychosis. The ministry also committed to developing a comprehensive mental health and addiction strategy that would lead to better services for Ontarians. To support this direction, the Minister of Health and Long-Term Care recently:

- Established a Minister's Advisory Group on Mental Health and Addictions
- Held a Mental Health and Addictions Strategy Summit entitled *Open Minds. Healthy Minds* to further dialogue in this area
- Released a discussion paper, Every Door is the Right Door, as a starting point of discussion for the province's 10-year mental health and addictions strategy
- Finally, a series of roundtables and other public forums were held to gather the views of Ontarians who are familiar with mental health and addiction services.

In conclusion, mental health and addictions is a growing issue which requires a comprehensive, measured and action-oriented approach.

Improved Outcomes in Rehabilitation Care:

Generally, any kind of rehabilitation strives to meet one goal - to improve the lives of those who have been diagnosed with a disease or who have experienced injuries. Regardless of the cause or treatment required, rehabilitation can help people regain their social status

by enabling them to live normal and healthy lives. For patients who have been diagnosed with diseases, such as lung and heart problems, spinal disorders, cancer or other diseases/ injuries that may affect physical functions, rehabilitation can provide the needed help for the patients to return to work or home.

Studies have shown that inpatient rehabilitation can reduce inpatient length of stay and improve or maintain ambulation during prolonged hospital stays. The benefits of ambulation during prolonged hospitalization for coronary events have been widely recognized. After hospital discharge, the process of physical reconditioning is continued at home.

Within the Erie St. Clair LHIN, it is important to continue to pursue rehabilitation opportunities both in hospital (e.g., ambulation programming) or in the community (e.g., intensive rehab outreach teams). These interventions are expected to have a positive benefit of lowering hospital length of stay, leading to improved ALC flow, and maintaining or improving a patient's ambulation capability. Rehabilitation services keep people in their homes longer and safer, with supervised supports, and reduce rates of hospitalization and re-hospitalization for post operative clients.

Section 8: How Success will be Demonstrated – Actions and Measures

As stated in the introduction of this document, the overall direction of the 2010-2013 IHSP has evolved from being primarily a strategic high-level document in 2006-2009 to an action-focused, results-based document that provides information on milestones, specific enabling actions and anticipated impacts or success measures. These elements are covered in detailed Annual and 90-day Action Plans that have been advanced by the ESC LHIN Advisory Networks. (See Appendix E for detailed Annual and 90-day Action Plans across each priority area.)

The ESC LHIN will use these Action Plans along with the formal ESC LHIN Advisory Networks to guide and monitor progress within 90-day review cycles and ensure that established targets are being met and adjustments are made as needed. This information will be considered in the wider context of the new the MLAA performance indicators, Ministry of Health and Long-Term Care Priorities, and LHIN System Level (three-year period) success measures - measures that link directly to the LHIN vision and mission. The following section of this document provides information on actions and measures of success across the five IHSP priority areas (ALC, ED, Diabetes, Mental Health and Addictions and Rehabilitation Care and Interventions).

Section 8: How Success will be Demonstrated – Actions and Measures

Alternate Level of Care (ALC)

– Plans for 12 to 36 months

Success Measures

- Reduce acute care ALC days by 5%
- Increase % of patients returning to pre-hospital environment by 5%
- Decrease the % of patients placed in long-term care facility post acute by 5%
- Ensure 75% of all appropriate patients on target units receive ambulation to avoid de-conditioning
- Improved knowledge/ satisfaction of patients and their families
- Maintain % ALC in hospital at or below MLAA negotiated target of 9%
- Significant increase in the utilization of services for the senior population
- 5% reduction of falls within long-term care homes
- Reduce percentage of patients over 60 admitted to hospital from home or rest / retirement home requiring post acute care by 15%

Action Highlights

- Review Compliance Branch issues and co-ordinate with potential rest/retirement homes to ensure patient safety
- Initiate education planning group to develop marketing / educational initiatives to mitigate ALC risks
- Enable expanded ambulation assistants and ambulation staff to all medical / surgical floors
- Develop key messages/market plan to highlight services offered by each long-term care home (video format)
- Develop mobile teams to address selected co-morbidities

Emergency Department (ED) Care
– Plans for 12 to 36 months

Success Measures

- Reduce wait times by 10% for priority patients (e.g., mental health, CTAS 4 & 5)
- Reduce admitted patient holds in the ED by 35%
- Reduce left-without-being-seen incidents by 3-5%
- Decrease hospital acute LOS for patients with CHF/ COPD
- Increase utilization of community support / services by 10%
- Improve patient discharge screening risk assessment completion to 100%
- Increase discharge follow-up for CHF/ COPD patients by 50%

Action Highlights

- Enable the development of strategies to better manage the assessment and admission process for mental health patients
- Expand the hours of Nurse Practitioner (NP) / Physician Assistant (PA) coverage for treat and release patients
- Develop a referral process to primary care initiated by the ED
- Standardization of Geriatric Emergency Medicine (GEM) Registered Nurse (RN) role to avoid unnecessary admission
- Continue/expand LEAN strategies
- Expand hours of operation for ED Fast track utilizing Physicians and NPs
- Develop communication and education strategy for community and wait room patients to offer alternatives to ED
- Develop a primary care path for CHF/ COPD
- Develop mechanisms so that unattached patients (CHF/ COPD) are auto-referred to NP and NP primary care clinic

Section 8: How Success will be Demonstrated – Actions and Measures

Diabetes
– Plans for 12 to 36 months

Success Measures

- Expanded teams to serve 100-200 new clients in the first year (team expected to serve up to 1000 clients within three years)
- 90% of patients with diabetes having a foot exam completed annually
- 90% of patients with diabetes having their eye exam completed every 1-2 years
- 80% of diabetes clients reporting satisfaction with DEP services
- 20-50% of diabetes clients reporting improved confidence and ability to self-care for DM
- Approximately 1-2% reduction in ED visits
- Approximate 1-2% reduction in length of stays for those hospitalized with diabetes-related complications

Action Highlights

- Provide oversite and support to newly established diabetes teams
- Explore and plan for one-stop multidisciplinary diabetes clinic per sub region
- Explore opportunities to use telehealth /Ontario Telemedicine Network for specialized consultation
- Enable divestment of diabetes education program to community from hospital
- Work with regional DEP to share best practice tools related to client satisfaction/confidence surveys

Section 8: How Success will be Demonstrated – Actions and Measures

Mental Health
– Plans for 12 to 36 months

Success Measures

- Reduce Mental Health ALC days by 5%
- Reduce time for referral to admission to service by 50%
- Reduce hospital admission rates by 5%
- Reduce hospital LOS by 2 days with the implementation of enhanced clinical pathways
- Reduced mental health ED visits by 60-120 patient visits/year and reduce readmissions by 10%/year
- Reduced Inpatient Geropsychiatry admission by 5-10%

Action Highlights

- Staff to work together across organizations to minimize the number of assessments, learn one another's role, and utilize community based resources more effectively in order to ensure timely discharges and transfer of care for patients
- Plan alternatives to hospitalization.
- Establish withdrawal management services for each sub-region
- Increase community education and promotion of community crisis services
- Enable a community based mood disorders program; provide information and education about the service to primary care providers, ED physicians/staff and other key referral sources

Section 8: How Success will be Demonstrated – Actions and Measures

Addictions
– Plans for 12 to 36 months

Success Measures

Adults with an Opiate Dependency

- Wait times (referral to intervention) for outpatient withdrawal management and addiction medicine services reduced by 5 to 10 days
- Wait list attrition reduced by 20%
- Number of ED visits reduced by patients presenting for withdrawal management and addiction medicine by 10%
- Acute care deferrals from inpatient withdrawal management services reduced by 25%
- Successful treatment compliance rates increased by 20%

Youth and Seniors with Addictions

- Reduced time, cost and barriers to service access

Action Highlights

Adults with an Opiate Dependency

- Enable Re-activation of former outpatient withdrawal management model and expand current day treatment services
- Enable referral to outpatient/day treatment service and enable **a** reduction in non-acute inpatient admissions
- Enable expanded existing day treatment program

Youth and Seniors with Addictions

- Enable the reintroduction of outreach programs into secondary schools system
- Enable the development of a pre-operational plan, operational framework, and service structure for population

Rehabilitation & Interventions
– Plans for 12 to 36 months

Success Measures

- 5% reduction in length of stay for selected chronic conditions
- Improve Activities of Daily Living (ADL) functioning by 10% or maintain ADL functioning for 6 months post programming
- Increase patients discharged from rehab to home by 10%.
- Decrease the total LOS (acute plus rehab) by two days for top CMGs (case mix groups) such as stroke, hip fracture, etc.
- Decreased incidence of skin breakdown by 5-10%

Action Highlights

- Enable development of client maintenance programs through general community exercise programs, e.g. SMART or in-home programs
- Enable improved caregiver assessments and support programming
- Enable improved utilization of geriatric emergency nurses
- Transition to patient self-management programs for chronic diseases (e.g., Arthritis Society)
- Enable automatic e-referral
- Development and implementation of satisfaction measures for care team and patient/family

Appendices:	Information Included:
A – Description of Community Engagement (CE) Process	Description of Groups, Methods, Processes, Level of Engagement
B – Population Profiles	Detailed Data on Population, Demographics, Health Status, Health Conditions and other Statistics (e.g., Dialysis, Chronic Disease Management, etc.)
C – Needs Assessment	Community engagement findings (all areas – interviews, focus groups, Facebook, etc.) SWOT (Strengths, Weaknesses, Opportunities, Threats) Analysis Wait Times Report for ESC LHIN
D – Services, Resources and Programs	ESC LHIN Service Inventory
E – Funding and Planning Strategies	Funding Aging at Home and Urgent Priorities Detailed copies of Annual and 90-day Action Plans across all priority areas
F – LHIN Leads Report and Themes Reports	LHIN Lead Reports: • e-Health • Critical Care • French Language • Aboriginal Health Care • Infection Control • Pharmacy Themed Reports: • System Navigation • Health and Human Resources • Surgery Network (and Diagnostic Imaging) • Integration Areas (CHC, CMHA)
G – ESC LHIN Health System Targets	Table on System Targets (three-year strategic range)
H – Triple Aim Approach	Greater detail on Triple Aim
I – Bibliography	

Our Vision

A health care system that helps people stay healthy, delivers good care to them when they get sick, and will be there for their children and grandchildren.

Erie St. Clair LHIN

180 Riverview Drive
Chatham ON N7M 5Z8
Phone: 519-351-5677 or 1-866-231-5446
Fax: 519-351-9672

www.eriestclairlhin.on.ca

Visit us on Facebook